HIMANSHU P. PARIKH, M.D.P.C.

NEW PATIENT REGISTRATION FORM

DATE: _____

PATIENT INFORMATION

NAME: _____

DATE OF BIRTH: _____ SEX: ☐ MALE ☐ FEMALE

ADDRESS: _____

STREET CITY STATE ZIP CODE

PHONE NUMBER, CHECK PREFERRED

	CELL:
	HOME:
	WORK:

SOCIAL SECURITY: _____

EMAIL: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORED

EMPLOYMENT STATUS: ☐ F/T ☐ P/T ☐ STUDENT ☐ UNEMPLOYED ☐ DISABLED ☐ RETIRED

EDUCATION: ☐ ELEMTARY ☐ HIGH SCHOOL ☐ UNDERGRADUATE ☐ GRADUATE ☐ HIGHER ☐ MASTER ☐ DOCORATE

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPACIC OR LATINO ☐ UNKNOWN/DECLINED

RACE: ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWIAAN OR OTHER PACIFIC ISLANDER ☐ OTHER RACE ☐ WHITE ☐ UNKNOWN OR DECLINED

PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH OR CASTILIAN ☐ OTHER

PRIMARY INSURANCE

INSURANCE COMPANY: _____

POLICY ID #: _____ GROUP: _____

IF POLICY HOLDER IS OTHER THAN SELF, COMPLETE THE SECTION BELOW.

POLICY HOLDER NAME: _____ RELATION TO PATIENT: _____

DATE OF BIRTH: _____ SEX: ☐ M ☐ F SOCIAL SECURITY #: _____

SECONDARY INSURANCE

INSURANCE COMPANY: _____

POLICY ID #: _____ GROUP #: _____

POLICY HOLDER NAME: _____

ALLERGY ALERT

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ YES ☐ NO ☐ I DON'T KNOW

IF YES, LIST MEDICATIONS: _____

IS YOUR CONDITION RELATED TO EMPLOYMENT? ☐ YES ☐ NO

IF YES, COMPLETE THE SECTION BELOW.

EMPLOYER'S NAME: _____ EMPLOYER'S PHONE #: _____

EMPLOYER'S ADDRESS: _____

IS YOUR CONDITION RELATED TO AN AUTO ACCIDENT? ☐ YES ☐ NO

IF YES, COMPLETE THE SECTION BELOW.

NAME OF AUTO INSURANCE: _____DATE OF ACCIDENT: _____

EMERGENCY CONTACT

NAME: _____ PHONE #: _____

RELATIONSHIP TO PATIENT: _____

HOW DID YOU HEAR OF OUR PRACTICE? _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I hereby authorize for Dr. Himanshu Parikh, M.D. to release any information acquired in the course of my examination or treatment to specific insurance carriers, third party payers, or others involved in the processing and collecting of claims in accordance with the HIPPA Patient Confidentiality Act of 1996.

SIGNITURE_____ DATE_____